HOSPITAL CARE FOR THE INDIGENT (HCI)

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GENERAL INFORMATION

Indiana's Hospital Care for the Indigent (HCI) program is a State program that provides assistance to eligible uninsured individuals to pay for the cost of emergency care provided in an Indiana hospital. Hospitals, physicians, and transportation providers can be reimbursed by the program for services rendered to eligible HCI recipients.

HCI is available to eligible individuals who are Indiana residents, and also to eligible individuals who are not Indiana residents if the onset of the medical condition that required hospital care occurred in Indiana. Either the individual, the individual's representative, or the hospital, physician, or transportation provider who provided care or services can file the HCI application with the Local Office of the Division of Family Resources.

Local Offices evaluate all eligibility factors EXCEPT the medical criteria. The Central Office HCI Unit makes the determination as to whether the hospitalization is a qualifying one under the emergency criteria listed below when the hospital files their claim for payment and after the Local Office has determined financial eligibility:

> The hospital care had to be necessitated by the onset of a medical condition that manifested itself by symptoms of sufficient severity that the absence of immediate medical attention would probably result in:
>
> 1) placing the person's life in jeopardy;
> 2) serious impairment to bodily functions; or
> 3) serious dysfunction of any bodily organ or part.
>
> For Indiana residents, assistance includes payment for care in the hospital that is a direct consequence of the medical condition that necessitated the emergency care.

Eligibility for HCI is determined on a month- by- month basis. If covered services extend over more than one month, a separate eligibility determination is required for each month.

I. Non-financial Requirements

A. Residency

Indiana residents who meet all program requirements are eligible for HCI.

A non-resident who meets all other eligibility factors is eligible for HCI if the onset of the emergency condition that required care occurred in Indiana. Assistance to non-residents is not available for care that is a direct consequence of the medical condition that necessitated the emergency care.

B. Citizenship

In order to be eligible for HCI, the patient must be a citizen of the United States or a non-citizen who is in the U.S. lawfully with valid documentation from Citizenship and Immigration Services (formerly the INS). Undocumented immigrants are not eligible for HCI.

C. Institutional Status

Inmates or patients of institutions of the Department of Correction, Department of Health, the Division of Mental Health and Addictions, or the Division of Disability, Aging, and Rehabilitative Services are not eligible for HCI. (County jails are not institutions of the Department of Correction.)

II. Financial Eligibility Requirements

The income and resources of the patient and other members of the household unit are considered in the financial eligibility determination for HCI. The steps in the financial eligibility determination are as follows:

1) Identify the individuals who, based on their relationship to the patient, may be included in the household unit;

2) Determine the countable income of each household unit member;

3) Determine the Household Size;

4) Compare total countable income of the household unit, to the appropriate income standard for the patient's Household Size;

5) Determine the countable resources in accordance with Section C and compare that amount to the appropriate resource limit.

A. Household Unit

In order to determine the financial eligibility of an individual for HCI, the individual's household unit must be established. The household unit consists of the persons listed below who live with the patient at any time during a calendar month.

If the patient is age 18 or older, or under age 18 and married, the household unit consists of:

- the patient;
- the patient's spouse;
- the patient's biological, adoptive, and step-children under age 18 whose monthly countable income is less than or equal to $199.00.

If the patient is unmarried and under age 18, the household unit consists of:

- the patient;
- the patient's biological or adoptive parent(s);
- the patient's step-parent if the step-parent's monthly countable income is equal to or less than $199.00 and, the patient's natural parent lives in the household;
- the patient's biological, adoptive, or step-siblings under age 18 whose countable income is less than or equal to $199.00.
- the patient's biological and adoptive children whose monthly countable income is less than or equal to $199.00.

Other persons are not included in the household unit. The number of persons in the household unit as described in this section is the “household size” and establishes the income standard that is applied in the financial eligibility determination.

B. Income

Income is all money received by the patient and the other members of his household unit. This includes earned income and unearned income. The exception is a tax refund, which is counted as a resource. In-kind income is not considered.

Monthly income is considered in the budget in the month it is received. Earned income is considered available on the date the paycheck is actually received, not for the pay period the check covers. The only exceptions are "direct deposit" benefit checks which are sometimes recorded by the bank at the end of one month instead of at the beginning of the month in which they are normally received (and in which they should be counted).
Income that is received less often than monthly, such as quarterly or semi-annually, is

to be prorated by the number of months indicated by the frequency of receipt of the income. This type of income is countable only if received during a month of hospital care. The prorated amount is then reflected in the budget for each month assistance is requested. This procedure does not apply to self-employment income.

1. Unearned Income

Unearned income is all income that does not meet the definition of earned income below. Unearned income received by the patient and other household unit members is countable, subject to certain disregards that are explained later in item B. 3. A Social Security benefit is an example of unearned income. The gross benefit amount before deductions is the amount that is counted as income.

Rental Income

Rental income is payment for the use of real or personal property. Rental payments may be received for the use of land (including farmland), for land and buildings, for a room, apartment or house, or for machinery and equipment. Refer to Sections 3420.00.00, 3420.05.00, and 3420.05.05 of the ICES Program Policy Manual for further instructions regarding rental income. Follow the instructions that apply to MED 1 and 4.

2. Earned Income

Earned income is payment from an employer or from self-employment. Earned income can be wages, salaries, and commissions. Distinguishing earned income from unearned income is important to ensure that the earned income disregard is correctly applied.

Income from Employment

Income from employment must be verified. Sources of verification are:

- Employer's wage records by use of Form 65, Request for Information Regarding Earnings;
- Pay stubs - provided the pay periods are identified or another means of verification is obtained to assure that the patient has provided all pay stubs for the calendar month(s) of hospitalization;
- Indiana Department of Revenue's records by use of Form 19, Request for Information from Indiana Department of Revenue.

The countable earned income from employment is determined by subtracting $65 from the total for the month and dividing the remainder by 2.

Income from Self-Employment

Net Income from self-employment, including a small business or farming operation is determined by deducting expenses allowed by the IRS from gross income.

If self-employment is involved, refer to the ICES Program Policy Manual Sections 3410.10.00 and 3410.15.00 for explanation of how net income is to be determined. Follow instructions for MED 1 and 4. $65 is subtracted from the net income, plus ½ of the remainder to determine countable income from self-employment.

3. Disregarded Income

Once the gross monthly incomes of the patient and household members are determined, the following disregards must be applied to determine the countable income.

a. Supplemental Security Income (SSI) benefits received by the patient;

b. $15.50 of the patient's total income;

c. All of the earned income of a child under age 14;

d. Funds from a grant, scholarship, or fellowship which are designated for tuition and mandatory books and fees at an educational institution or for vocational rehabilitation or technical training purposes;

e. Income tax refunds (these are countable resources);

f. Home energy assistance;

g. A loan in the month of receipt if the written or verbal loan agreement is legally binding under State law and includes the following:

- The borrower's acknowledgment of an obligation to repay;
- A timetable and plan for repayments; and
- The borrower's expressed intent to repay either by pledging real or personal property or anticipated income.

4. Income Budgeting Procedures

Eligibility for HCI with regard to income is based on the total countable income of the household unit. If the countable income of the household unit exceeds the income standard for the patient's household size, the patient is ineligible for HCI. If the income equals or is less than the income standard, the patient is eligible if all other requirements are met.

Form 5H, Hospital Care for the Indigent-Budget and Recommendation, is used to compute income eligibility.

Income Standards

The following monthly income standards are to be used for hospitalizations beginning on October 1, 2004 through September 30, 2006. These standards are adjusted every two years.

Household Size	Income Standard
1	$ 582.00
2	$ 781.00
3	$ 980.00
4	$1179.00
Each additional member	199.00

C. Resources

Resources are the real and personal property owned by the patient and other members of the household unit and are subject to the resource limitations listed below. Tax refunds are considered resources, not income.

All resources must be verified. Information and verification are to be recorded on the application.

In evaluating resources the following definitions are applicable:

- Current market value - the average price that the property will sell for on the open market to a private individual in the particular geographic area involved.

- Equity value - the current market value minus the total amount of liens against the property.

1. Resource Limits

A patient is ineligible for HCI if the total equity value of available non-exempt real and personal property owned by the members of the household unit exceeds the applicable limit during any part of the month(s) of hospitalization. The resource limits are as follows:

(a) $1500 for an unmarried patient, or for a patient not living with his spouse;

(b) $2250 for a married patient and his spouse if the couple is living together;

(c) For the patient who is an unmarried child under age 18 living with his parent(s) the resource limit for his parent(s) is as follows:

- $1500 for a biological or adoptive parent who is unmarried or separated from his spouse; or
- $2250 for biological or adoptive parents living together.

The excess resources of the parent(s) are to be applied toward the patient's resource limit of $1500. However, if the patient's own resources exceed $1500, his excess cannot be applied to his parents.

2. Personal Property

The equity value of all personal property owned by the patient and other members of the household unit must be verified and evaluated for the HCI resource determination.

Personal property includes but is not necessarily limited to the following:

- Cash on hand;
- Contents of a safety deposit box;
- Stocks and bonds;
- Income tax refunds;
- Bank accounts. Refer to the ICES Program Policy Manual Sections 2615.10.00 through 2615.10.15.
- Cash surrender value (CSV) of life insurance owned by the patient and other members of the household unit;
- Motor vehicles; and
- Recreational vehicles, campers, trailers, etc.

a. Exempt Personal Property

The following personal property is exempt:

1. One motor vehicle if it is necessary for employment or medical treatment or is modified for operation by or transportation of a handicapped person. If more than one vehicle qualifies for the exemption, the vehicle with the highest equity value is exempt. If no motor vehicle qualifies to be excluded for one of the 3 stated reasons, $4500 of the current market value of one motor vehicle is exempt. The equity value of other vehicles is countable.

2. The cash surrender value of life insurance by which the patient is insured, if the total face value does not exceed $1400 and the beneficiary is the funeral director (who will be providing services) or the patient's estate. If the total face value of all policies owned by patient exceeds $1400, the CSV must be counted as a resource. The $1400 limitation is reduced by any amount in an irrevocable burial trust. Policies that insure the other members of the household unit cannot be exempt under this provision.

3. Irrevocable burial trusts set up in accordance with I.C. 30-2-10 et. seq.. Burial trusts set up in other states may be irrevocable according to laws of that state and must be evaluated accordingly.

4. All household goods and personal effects. Refer to ICES Program Policy Manual Section 2615.30.00.

5. Personal property used to produce food for home consumption or used in the production of income;

6. Personal property owned solely by children under age 18, other than the patient;

7. Personal property owned solely by the step-parents of the unmarried patient under age 18;

8. Property which is the patient's home, such as a mobile home or trailer.

3. Real Property

The equity value of all non-exempt real property (including life estates) owned by the patient and other members of the household unit must be verified and considered in the resource determination. Agreeing to sell or rent, does not exempt real property.

a. Exempt Real Property

The following real property is exempt:

1. The home which is the patient's principal place of residence;
2. Real property owned solely by children under age 18 other than the patient, or by the step-parent of the unmarried patient under age 18; and
3. Burial spaces.

III. Case Processing

A. Filing the Application

An application for HCI can be filed by the patient, the patient's representative or by the hospital, physician, or transportation provider. However, the application must be filed with the Local Office not more than 45 days (plus 3 days if the application is mailed) after the date of hospital discharge/release. Weekends and holidays are included in this count. The *original* of the signed application must be submitted to the Local Office, not a copy. Faxed applications are permissible if necessary to meet the filing deadline. The original must then be submitted.

Form HCI-1, Application for Hospital Care for the Indigent, must be completed for each event of hospitalization or hospital care and signed by the patient. If the patient is medically unable to sign the application, it may be signed by his next of kin or legal representative. A hospital representative may sign the application in his or her own name, on behalf of the hospital if the patient is medically unable and the next of kin or legal representative is unavailable. Refer to III A.4 for information about authorized representatives and hospital agents.

When a patient is transferred from one hospital to another, a separate application must be filed for the new admission.

1. County in which Application is Filed

An application for HCI is to be filed with the Local Office in the county where the patient resides.

The county of residence must be immediately verified by the Local Office. If the patient resides in a different county, the application must be forwarded by the first receiving county within 3 days to the Local Office in the county where the patient lives. State Form 5022/FI Form 2002, Notification of Transfer of Application for HCI, must be used for this purpose and attached to the application. A copy of the form must be sent to the hospital and to the patient.

If the patient is not an Indiana resident or his place of residence cannot be determined, the Local Office of the county where the illness or injury occurred will determine HCI eligibility.

2. Registering the Application

The Local Office registers the application in the "HCI On-Line" system, which will assign the case number. Refer to the HCI On-Line User Manual. Applications should be registered immediately upon receipt by the local office.

3. Time Standard

The time standard for completion of the eligibility determination, which does not include the Central Office's decision regarding payment of claims based on emergency criteria, is 45 days after the date the application is received by the Local Office. When an application has been transferred, the date of application is the date the application was received by the first Local Office. Refer to Sections III B and C regarding timely and untimely application processing.

When an application for HCI is received by the Local Office, the caseworker should encourage the applicant to apply for Medicaid if the applicant might be eligible. However the application for HCI cannot be denied if the applicant refuses to do so, nor can it be pended beyond the time standard until eligibility for Medicaid is determined.

4. Authorized Representatives and Hospital Agents

As stated in item III.A, an HCI application must be signed by the patient unless he is medically unable to sign. If he is medically unable to sign the application, his legal representative or next of kin may sign. A hospital representative may only sign an HCI application if the patient is medically unable to sign and the next of kin or legal representative is unavailable. Instances in which the hospital has signed the HCI application are expected to be very infrequent as hospitals are expected to set up procedures for their indigent patients and or families to be informed of HCI prior to discharge.

A hospital representative or agent, such as an eligibility assistance company cannot act as the patient's authorized representative. If the patient, next of kin, or legal representative has signed the application, that person will continue to be the person with whom the Local Office will work during the processing of the application. The hospital representative is not the patient's authorized representative in this situation. However, the state law does give the hospital the right to assist in the preparation of the application. In this capacity, the hospital representative can help the applicant in obtaining financial verifications and can provide this information to the Local Office without the Local Office requiring any type of signed release from the patient. Similarly, if the hospital or eligibility company signs the application, he or she can continue to help the patient to obtain necessary verifications. This is done in the role of hospital representative, not "authorized representative" acting on behalf of the patient.

B. Eligibility Determination Process

All applications must be registered in the HCI On-line system, immediately upon receipt to obtain the case number. The Local Office will then determine whether or not a personal interview with the patient is needed to determine eligibility. Generally an interview will be necessary to obtain required information, however if an application, signed by the patient, is submitted with all documentation and verification included, the interview can be waived by the Local Office. If the Local Office determines that an appointment is necessary, an appointment letter is to be sent to the applicant with a copy to the hospital.

An application interview can take place in the office or by telephone.

If the application was filed by the patient or next of kin, the worker must also contact the hospital to obtain any information it may have concerning the patient's HCI eligibility. If the hospital filed the application, it is expected that all information known or collected by the hospital be included with the application. The patient is responsible for cooperating in obtaining all information and assisting the caseworker in obtaining verifications necessary to determine his eligibility. If the applicant does not have necessary documentation, he or she must sign consent forms so that the caseworker can obtain it.

Once the caseworker has determined all elements that require cooperation/documentation from the applicant, the letter entitled "Letter to Applicant Requesting Necessary Information" must be sent to the applicant and/or his representative with a copy to the hospital. (Refer to the Appendix for the letter to be used.) A due date of 10 days (plus 3 if mailed) must be given. If the

applicant fails to provide the information by the due date, the application cannot be denied at this point. The Local Office must send the Final Letter Requesting Information for HCI to the applicant or the applicant's representative, the hospital, and the physician and transportation providers who have submitted claims. A copy of this letter will not be sent to physicians and transportation providers who have not yet submitted their claims. The deadline for providing the required information is to be no later than the 55th day after the date of application, and the letter must be sent not later than the 45th day after the date of application. The extra 10 days beyond the time standard is required by the state law in circumstances when required information has not been provided to the local office.

If the required information is not received by the 55th day, the application is to be denied on the 56th day. Refer to Section C.1.

If the required information is received by the 55th day, the Local Office must finish the application in 10 days. For example, if the information is received on the 50th day, the decision must be made no later than the 60th day; or if the information is received on the 55th day, the decision must be made no later than the 65th day after the date of application. If the Local Office does not make the eligibility determination within the 10 days, the application is automatically approved. Refer to Section C.

C. Disposition of the Application

1. Local Office Timely Determines that Patient is not Eligible

   A timely determination is one in which the Local Office has received the necessary information within 45 days after the application date and makes the determination/issues the Certificate of Action no later than the 45th day; or one in which information was not received timely and the Local Office followed the procedures in B. above.

   a. The Local Office denies the application.

   - Prepare the Form HCI-2, Certificate of Action, in quadruplicate, taking care to make sure all copies are legible. The original is sent to the patient with a copy to the hospital. The pink copy is sent to the Central Office HCI Unit, and the gold copy is retained in the case record by the Local Office.

- The Form HCI-2 must include the specific dates of hospitalization, the reason(s) for denial, and the specific state law or regulation supporting the action. A list of reasons and supporting legal authority is included in Section VII.

- The Local Office Director's authorized signature must be on the Certificate of Action.

2. Local Office does not Determine Eligibility Timely

a. The Local Office completes an automatic approval of the application.

- If the application was not processed timely, in accordance with preceding instructions, it must be automatically approved. The local office is to check the box on the HCI-2 that states: Your application has been approved without an eligibility determination because it was not processed within time standards set forth in state law.

- The Local Office Director's authorized signature must be on the Certificate of Action. Copies of the Certificate are to be distributed as explained in the preceding section C.1.

- Provider claims and any medical information that the hospital may have submitted are to be attached to the HCI Unit's copy of the Certificate.

3. Local Office Timely Determines Patient is Eligible

a. The Local Office approves eligibility.

- Prepare the Form HCI-2, Certificate of Action, in quadruplicate, taking care to make sure all copies are legible. Specify months of eligibility if applicable. Check the appropriate box for Medicaid approved or pending, and or TPL. The original is sent to the patient with a copy to the hospital. The pink copy is sent to the Central Office HCI Unit, and the gold copy is retained in the case record by the Local Office.

- Until the HCI -2 is revised, the following paragraph that is on the Medical Eligibility side of the form must be circled and highlighted so that it prominently reflects that it applies to the decision:

  "This is notification of eligibility only, not a guarantee that bills incurred during the hospitalization will be paid the by the program. All claims submitted by providers will be considered for payment in accordance with pertinent statutes and regulations."

- The Local Office Director's authorized signature must be on the Certificate of Action.

- Provider claims and any medical information that the hospital may have submitted are to be attached to the HCI Unit's copy of the Certificate.

Local Offices have no obligation to mail separate Certificates of Action to eligibility assistance companies. These companies are hospital agents and if they need a copy, they must obtain it from the hospital. Furthermore, local offices have no obligation to respond to requests from hospitals or eligibility companies who provide lists of applications on a routine basis to obtain disposition updates.

IV. Medical Determination and Claims Submission by Providers

When the hospital receives the copy of the Certificate of Action approving HCI eligibility, it must submit its claim for payment with required medical information attached, no later than 180 days after the release/discharge of the patient from the hospital. Physicians and transportation providers must submit their claims within 180 days after the release/discharge of the patient from the hospital. The physician and transportation provider claims may be submitted along with the hospital's claim or they can be submitted later, as long as the claims are submitted within the 180-day timeframe. Physicians and transportation providers who want to receive the Local Office's requests for information letters that are sent to the patient, must file their claims with the Local Office while the application is pending. Refer to section IV.C regarding good cause to extend the filing period limitation.

The procedures for claim/medical information submission apply to applications that were timely approved by the Local Office as well as those that were automatically approved due to untimely processing.

Providers are to use the same claim forms as they use when filing with the Indiana Medicaid program. Claims are to be submitted to:

FSSA
HCI– MEDICAL TEAM MS 34
P.O. BOX 7128
402 West Washington Street
Indianapolis, Indiana 46207

A. Submission of Medical Information by the Hospital

The following medical information must be included with the hospital's claim for payment:

(1) Admission summary

(2) Operative Report if surgery was performed

(3) Progress Notes

(4) Discharge summary

(5) Any other medical information which the hospital wishes to provide to fully document the patient's condition, symptoms, treatment, etc., at the time of admission and/or during the course of the hospitalization.

B. Determination of Medical Eligibility

- The HCI Unit will determine if the patient is medically eligible for the program and review all submitted claims to determine whether items/services are reimbursable by the HCI program. A decision as to whether items on a claim meet the emergency requirement must be made within 45 days. Before denying a service on a claim, the HCI Unit will send a letter to the provider that offers the provider the opportunity to submit additional information that the provider believes substantiates that the service does meet the emergency criteria for payment by the program. The deadline for submitting the additional information is the 55th day after the HCI Unit received the claim, and the letter must be sent not later than the 45th day after receipt of the claim. This gives the provider, at minimum, 10 days to submit the information.

  When the HCI Unit receives the additional information, a decision must be made within 10 days, or the service is automatically determined to qualify for payment. If the required additional information is not received by the deadline, the HCI Unit will deny the claim or the individual service in question.

  - The HCI Unit will complete a Certificate of Action; and

  - Mail the original of the Certificate of Action to the patient and copies to the hospital and Local Office.

A claim form that is not properly completed will be returned to the provider by the HCI Unit.

C. Good Cause for Extending the Filing Limit

The 180 day filing limit will be extended by the HCI Unit only in the following circumstances:

(1) An undue delay occurred with the local DFR office in which the Certificate of Action automatically approving eligibility due to untimely processing was issued more than 150 days after the patient was discharged.

(2) An appeal resulting in a decision that overturned a DFR denial is issued more 150 days after the patient was discharged.

V. The Right to Appeal

The patient, his spouse or the parent of a patient under age 18, the hospital, physician, or transportation provider may file an appeal with the Central Office Hearings and Appeals Section if eligibility is not determined timely add reference, the patient was found ineligible for HCI, claims were denied because the hospitalization did not meet the emergency criteria, a claim is not processed timely, or part of a hospitalization was approved. The appeal must be filed within 90 days of the date of the Form HCI-2, Certificate of Action, Hospital Care for the Indigent. An appeal with regard to the failure of the Local Office to act promptly on an application must be filed within 90 days of the date of application. The request for a fair hearing must be in writing to the Local Office who will forward it to the Central Office, or the request can be sent directly to the Central Office Hearings and Appeals Section.

All parties will receive notice of the date, time, and location of the hearing, which will be conducted by a representative of the Central Office.

A. The Hearing Decision

The finding of fact and recommended decision will be in writing and will be distributed to the parties. The hearing decision is final unless an objection to the decision is filed within 10 days following receipt of the appeal decision.

B. Agency Review by the Family and Social Services Administration

When a written request for an Agency Review of the case by the Family and Social Services Administration is made within 10 days following receipt of the appeal decision such review will be granted. The Family and Social Services Administration will write to all parties to acknowledge receipt of the request and its acceptance for an Agency Review.

Any party aggrieved by the decision of the Agency Review by the Family and Social Services Administration may file a petition for Judicial Review in the appropriate court by following the procedures required by IC4-21.5 et seq.

VI. Recovery of HCI Assistance

Effective May 6, 2005, P.L. 145-2005 repealed the Indiana statute that allowed the State to recover from the eligible individual or responsible third parties, the amount of HCI payments made to physicians and transportation providers.

Clients who contact the Local Office for information regarding previous recovery actions or the amount that the HCI program has paid on his or her behalf should be referred to:

FSSA
HCI- MS #34
Revenue Recovery Unit

P.O. Box 7128
402 West Washington Street
Indianapolis, Indiana 46207

VII. Denial Reasons with Supporting Law or Regulation

1. Hospital Care in an out of state hospital is not covered by HCI
   IC 12-16-3.5
3. You are not a United States citizen or a lawfully residing non citizen
   IC 12-16-7.5-7
4. HCI is not available to persons residing _____ institution (specify institution)
   IC 12-16-2.5-5
5. Your income exceed the income standard of $_____. (Specify the standard used.)
   470 IAC 11.1-1-5
6. Your resources exceed the resource limit of $_____.
   470 IAC 11.1-1-6
7. Your application was filed after the 45-day filing limit
   IC 12-16-4.5-2
8. You did not provide information about _____ which was necessary to determine your eligibility. (Specify what was needed and not provided.)
   IC 12-16-5.5-3
9. You were covered by Medicaid in the month of hospitalization.
   42 CFR 433.139
10. You were covered by other insurance in the month of hospitalization.
11. You voluntarily withdrew your application for HCI.
    IC 12-16-4.5-1; IC 12-16-4.5-2; IC 12-16-4.5-8

Reason Codes to be used only by the HCI Unit

2. Your hospitalization does not meet the emergency criteria.
   IC 12-16-3.5-1; IC 12-16-3.5-2
12. We could not determine your medical eligibility because the hospital did not submit medical records.
    IC 12-16-5.5-3

HCI FORMS

Application for Hospital Care For The Indigent
State Form 27097(R3-1-97) / FI HC1 -001
(This is being revised as of the issuance of Transmittal #2)

Notification of Transfer of HCI Application
State Form 5022 / (R2/4-96)FI 2002

Budget and Recommendation - Hospital Care For The Indigent
State Form 5021/(R2/8-96) FI 0005H

Certificate of Action - Hospital Care For The Indigent
State Form 19154 (R8/7-05) / FI HCI 002

HCI PROGRAM CONTACT INFORMATION

Local Offices of Family Resources:

- For eligibility-related and general application processing questions, contact the Policy Answer Line.
- For questions relating to the medical determination, claims processing, and HCI On-Line contact the HCI Unit at 317/232-4320.
- For questions relating to Recovery, contact the Revenue Recovery Unit at 317/233-1459.

Hospitals:

- For eligibility-related questions, and case specific status information, contact the Local Office of Family Resources who is processing the application.
- For questions relating to the medical determination and claims processing, contact the HCI Unit at 317/232-4320.

REVISIONS TO HCI POLICY MANUAL

Revision #1 December, 2004	
Page Number(s)	Description of Revision
4	Updates income limits for inclusion of certain family members in the household unit
7	Updates income standards effective 10/1/2004
10-12	Clarifies signature requirement for hospitals; Defines policy regarding the role of the hospital and its agents in the application process
12	Clarifies requirement for personal interview
16	Specifies that hospital agents will not receive a certificate of action in addition to the copy sent to the hospital; Updates HCI Unit address
18	Clarifies repayment procedures
19	Updates denial reason codes and legal cites

Revision #2 September, 2005 This revision incorporates the provisions of P.L. 145-2005.	
Page Number(s)	Description of Revision
10	Adds requirement that an application is timely if filed not more than 45 days after discharge. Clarifies that the original, not a copy of the application must be filed with the Local Office.
11	Clarifies that applications must be immediately registered by the Local offices in the HCI On-Line system; identifies new procedure that separates the Local Office determination and applicable 45 day time standard from the medical/claims processing determination that has a separate 45 day time standard.
12-15	Clarifies that hospital is expected to include any information it has about the patient if the hospital files the application. Adds new procedures for Local Office eligibility determinations and application disposition.
15-16	Adds new procedures for hospitals to submit their claim and required medical information directly to the Central Office after the Local Office has determined that a patient is eligible. The separate 45 day process for determining the emergency qualification applies to all eligibility determinations – timely determinations and those that are auto-approved.
17	Adds good cause reasons for extending the 180-day claim submission time frame; Adds statutory provision giving appeal rights to transportation providers and physicians.
18	Recovery provision is repealed by statute.
19	Updates denial reason codes as a result of new law.
22-24	Adds form letters for use by Local Offices

APPENDIX – Form Letters

Letter to HCI Applicant Requesting Necessary Information

Final Letter Requesting Information for HCI

LETTER TO HCI APPLICANT REQUESTING NECESSARY INFORMATION

IMPORTANT

DATE:

Dear

We cannot finish processing your application for Hospital Care for the Indigent (HCI) because important information is needed to determine your eligibility for assistance.

It is your responsibility as required by State regulation (470 IAC 11.1-1-2) to verify or assist the Local Office in verifying all information necessary to determine your eligibility.

Please provide the following information:

If you need help in getting this information or you do not understand the eligibility requirements, please contact this office at _____.

Please provide this information no later than _____, so that we are able to process your application without further delay.

Sincerely,

_____

_____County Office
Division of Family Resources

cc: (hospital)
(transportation provider(s) if claim submitted)
(physician(s) if claim submitted)

FINAL LETTER REQUESTING INFORMATION FOR HCI

RE: (Name)
(Case Number)
Date of Application:

DATE:

Dear :

In a letter dated _____, you were informed that certain information was required so that your application for Hospital Care for the Indigent (HCI) could be finished. You have not provided the information listed below:

This information is required under state law and regulations, IC 12-16 and 470 IAC 11.1. Please submit the information to:

_____ County Office of Family Resources at the following address:

Fax: _____

If we do not receive the information by _____, the HCI application will be denied.

If you have any questions please contact me at _____.

Sincerely,

cc: (Hospital)
(Physicians and transportation providers who have submitted claims)